CHILD'S PROFILE

The following information will help us to better understand your child and his / her needs.

1. ARE THERE ANY KNOWN SPEECH, HEARING OR VISION DIFFICULTIES?

2. ARE THERE ANY MEDICAL PROBLEMS THAT REQUIRE SPECIAL ATTENTION OR OF WHICH WE SHOULD BE AWARE?

3. DOES YOUR CHILD DISPLAY ANY EMOTIONAL FEARS, BEHAVIOR PROBLEMS OR DIFFICULTIES IN DEALING WITH OTHERS?

4. DOES YOUR CHILD RECEIVE ANY SPECIAL SERVICES THROUGH SCHOOL?

5. IF YOU COULD DESCRIBE YOUR CHILD IN ONE PHRASE, WHAT WOULD IT BE?

6. WHY DO YOU WANT YOUR CHILD IN THIS PROGRAM?

7. ACTIVITIES YOUR CHILD **CANNOT** PARTICIPATE IN?

8. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD?

PARENT / GUARDIAN AGREEMENT

I, the undersigned, hereby enroll my child, _____ in the Volunteer Internship Program managed by the City of Rochester, Youth Services located at 80 Commercial Street, Rochester, New York, 14614. It is understood that the Volunteer Internship Program assumes responsibility for my child's well being during the hours of the program and will make every effort to immediately contact the parent/guardian should any type of emergency arise.

I have provided the staff with pertinent, complete and correct information which may assist the Volunteer Internship Program in caring for my child, including, but not limited to: allergies, pervious or existing illnesses or conditions, sunburn sensitivity, diet requirement, long-term medication, disabilities or limiting conditions, emotional development or behavioral difficulties.

The Volunteer Internship Program for my child begins when the child has reached the program and checked in with a Volunteer Internship Program staff person.

It is my responsibility to arrange for my child to be picked up at dismissal time. If my child is not picked up on time and attempts to contact me have failed, another authorized person will be contacted. If all attempts to contact an authorized person to pick up my child have failed, the Volunteer Internship Program will contact Child Protective Services and/or police officials.

I hereby give permission to record the image and/or voice of my child for newsletters, special projects, brochures, web sites or newspaper releases. I understand that I will not be informed or reimbursed for such photographs or videos.

Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.

The Volunteer Internship Program is mandated by the state law to report any suspected cases of child abuse or neglect to the appropriate authorities.

My signature acknowledges my understanding of, and agreement to the above and that all information I provide is accurate and complete.

PARENT / GUARDIAN SIGNATURE _____ DATE _____

PARENT / GUARDIAN NAME- PRINTED _____ RELATIONSHIP TO CHILD _____

#10963-0107pd

2007 PARENT INFORMATION APPLICATION

Volunteer Internship Program

Volunteer Internship Program "VIP" is a community program that rewards students ages 12-14 with volunteer opportunities that expose them to the world of work.

Who's Eligible?
City of Rochester youth currently enrolled in high school, ages 12-14, who have a 2.0 ("C" average) or higher GPA for the current parking period, have minimum 90% school attendance for the year, and have not had a long-term (five days or more) suspension during the school year.

Where to Apply?
Youth Services
80 Commercial Street
Rochester, NY 14614
585-428-6448

one city ROCHESTER

Robert J. Duffy, Mayor
City of Rochester, NY

CHILD / FAMILY INFORMATION

To be completed by parent/guardian. Please complete al the information (printing clearly in black or blue ink) and sign where required.

CHILD'S NAME _____
NICKNAME STUDENT ID #

MALE ____ **FEMALE** ____ **BIRTHDAY** _____ **AGE** _____

SCHOOL ATTENDING _____

CURRENT GRADE _____ ATTACH A COPY OF MOST RECENT REPORT CARD

City of Rochester youth ages 12-14 must have:
- A 2.0 ("C" average) or higher GPA for the current marking period.
- Minimum 90% school attendance for the year.
- No long term suspensions during the school year.

HOME ADDRESS _____ **ZIP** _____

HOME TELEPHONE NUMBER ( ) _____ **LANGUAGES SPOKEN AT HOME** _____

PARENT / GUARDIAN INFORMATION

MOTHER / GUARDIAN NAME _____ FATHER / GUARDIAN NAME _____

ADDRESS _____ ADDRESS _____

HOME PHONE _____ HOME PHONE _____

WORK PHONE _____ WORK PHONE _____

PLACE OF EMPLOYMENT _____ PLACE OF EMPLOYMENT _____

EMERGENCY INFORMATION / CHILD PICK-UP AUTHORIZATION

If my child requires emergency medical care and I cannot be reached, I give my consent to the Volunteer Internship Program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives.

In case of emergency, and the Volunteer Internship Program staff are unable to reach the parent/guardian listed above, the following individuals have permission to make decisions regarding the care of my child, including permission to pick up my child from the Volunteer Internship Program in case of an emergency or dismissal from the program:

NAME _____ NAME _____

RELATIONSHIP TO CHILD _____ RELATIONSHIP TO CHILD _____

HOME PHONE _____ WORK PHONE _____ HOME PHONE _____ WORK PHONE _____

ADDRESS _____ ADDRESS _____

HEALTH INFORMATION

Indicate YES where it applies and explain as necessary below

Asthma		**Hearing**		**Operations**	
Diabetes		**Vision**		**Hay Fever**	
Special Diet		**Illness**		**Poison Ivy**	
Convulsions		**Injury**		**Insect Bite Allergies**	
Physical Restrictions		**Psychological / Emotional**		**Medication**	
Learning Disabilities		**ADD / ADHA**		**Food Allergies**	
Allergies		**Other**		**Other**	

PLEASE EXPLAIN ALL YES ANSWERS FROM ABOVE:

_____

_____

_____

_____

_____

IS YOUR CHILD CURRENTLY TAKING PRESCRIBED OR OVER-THE-COUNTER MEDICATION? YES _____ NO _____

IS YOUR CHILD COVERED BY ANY HOSPITALIZATION / MEDICAL CARE POLICY? YES _____ NO _____

Please provide a copy of your hospitalization card. *(A copy can be made by staff for your convenience.)*

MEDICAL DOCTOR _____

ADDRESS _____

PHONE NUMBER _____